COPY

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 1/1/2018 To: 1/31/2018

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$57,348.00	$3,292.00	$60,640.00	$116,593.00			
Travel				$1,275.00			
Consultation Services	$270,290.00	$14,595.00	$284,885.00	$638,020.50			
Equipment							
Supplies	$630.00	$35.00	$665.00	$1,260.00			
Training							
Other (List Separately)							
Contractual Services	$7,220.00	$355.00	$7,575.00	$19,692.00			
Advertising	$23,664.00		$23,664.00	$61,500.00			
Administration/Indirect Costs	$5,730.00	$329.00	$6,059.00	$11,659.50			
Sub-Total	$364,882.00	$18,606.00	$383,488.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$364,882.00		$383,488.00	$850,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$18,606.00**

Program Income

Received To Date	Expended To Date	Remaining Balance

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hensley
Date: 2-9-18
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Nicole A Cu
Date: 2/12/2018

Program Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 1-10-18
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 12/1/2017 To: 12/31/2017

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$54,056.00	$3,292.00	$57,348.00	$116,593.00			
Travel				$1,275.00			
Consultation Services	$252,180.00	$18,110.00	$270,290.00	$638,020.50			
Equipment							
Supplies	$595.00	$35.00	$630.00	$1,260.00			
Training							
Other (List Separately)							
Contractual Services	$6,807.00	$413.00	$7,220.00	$19,692.00			
Advertising	$23,664.00		$23,664.00	$61,500.00			
Administration/Indirect Costs	$5,401.00	$329.00	$5,730.00	$11,659.50			
Sub-Total	$342,703.00	$22,179.00	$364,882.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$342,703.00		$364,882.00	$850,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) $22,179.00

Program Income

DEPARTMENT APPROVAL

Program Director By: Michael Cox
Date: 1/16/2018

Division Director By:
Date:

Program Accountant By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION
I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 12-12-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL
Program Director
By: Michelle A Gu
Date: 12/27/2017
Division Director
By:
Date:
Program Accountant
By:
Date:

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 11/1/2017 To: 11/30/2017

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$50,764.00	$3,292.00	$54,056.00	$116,593.00			
Travel				$1,275.00			
Consultation Services	$236,010.00	$16,170.00	$252,180.00	$638,020.50			
Equipment							
Supplies	$560.00	$35.00	$595.00	$1,260.00			
Training							
Other (List Separately)							
Contractual Services	$6,394.00	$413.00	$6,807.00	$19,692.00			
Advertising	$23,664.00	$0.00	$23,664.00	$61,500.00			
Administration/Indirect Costs	$5,072.00	$329.00	$5,401.00	$11,659.50			
Sub-Total	$322,464.00	$20,239.00	$342,703.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$322,464.00		$342,703.00	$850,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$20,239.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 10/1/2017 To: 10/31/2017

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$47,472.00	$3,292.00	$50,764.00	$116,593.00			
Travel				$1,275.00			
Consultation Services	$216,345.00	$19,665.00	$236,010.00	$638,020.50			
Equipment							
Supplies	$525.00	$35.00	$560.00	$1,260.00			
Training							
Other (List Separately)							
Contractual Services	$5,981.00	$413.00	$6,394.00	$19,692.00			
Advertising	$23,664.00		$23,664.00	$61,500.00			
Administration/Indirect Costs	$4,743.00	$329.00	$5,072.00	$11,659.50			
Sub-Total	$298,730.00	$23,734.00	$322,464.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$298,730.00		$322,464.00	$850,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$23,734.00**

Program Income	Received To Date	Expended To Date	Remaining Balance

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hensley
Date: 11-8-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Michelle A Gee
Date: 11/15/2017

Program Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hanley
Date: 10-11-17
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 9/1/2017 To: 9/30/2017

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$44,180.00	$3,292.00	$47,472.00	$116,593.00			
Travel				$1,275.00			
Consultation Services	$197,730.00	$18,615.00	$216,345.00	$638,020.50			
Equipment							
Supplies	$490.00	$35.00	$525.00	$1,260.00			
Training							
Other (List Separately)							
Contractual Services	$5,568.00	$413.00	$5,981.00	$19,692.00			
Advertising	$23,664.00		$23,664.00	$61,500.00			
Administration/Indirect Costs	$4,414.00	$329.00	$4,743.00	$11,659.50			
Sub-Total	$276,046.00	$22,684.00	$298,730.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$276,046.00		$298,730.00	$850,000.00			
					Received To Date	Expended To Date	Remaining Balance
Program Income							

Total Amount Requested for Reimbursement: (This billing period) $22,684.00

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 10-14-2017

Program Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 8/1/2017 To: 8/31/2017

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$40,888.00	$3,292.00	$44,180.00	$116,593.00			
Travel				$1,275.00			
Consultation Services	$179,090.00	$18,640.00	$197,730.00	$638,020.50			
Equipment							
Supplies	$455.00	$35.00	$490.00	$1,260.00			
Training							
Other (List Separately)							
Contractual Services	$5,155.00	$413.00	$5,568.00	$19,692.00			
Advertising	$23,664.00		$23,664.00	$61,500.00			
Administration/Indirect Costs	$4,085.00	$329.00	$4,414.00	$11,659.50			
Sub-Total	$253,337.00	$22,709.00	$276,046.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$253,337.00		$276,046.00	$850,000.00			

Total Amount Requested for Reimbursement: (This billing period) $22,709.00

Program Income	Received To Date	Expended To Date	Remaining Balance

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hurley

Date: 9-8-17

Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:

Date:

Division Director
By: Carol Carlberg

Date: 9-11-2017

Program Accountant
By:

Date:

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo
State: ND
Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2017 To: 6/30/2019

Billing Period: From: 7/1/2017 To: 7/31/2017

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)		$3,292.00	$3,292.00	$78,997.00			
Travel							
Consultation Services		$15,405.00	$15,405.00	$491,055.00			
Equipment							
Supplies		$35.00	$35.00	$840.00			
Training							
Other (List Separately)							
Contractual Services		$413.00	$413.00	$9,708.00			
Advertising				$11,500.00			
Administration/Indirect Costs		$329.00	$329.00	$7,900.00			
Sub-Total		$19,474.00	$19,474.00				
Less Advances/Program Income	( )	( )	( )				
Totals			$19,474.00	$600,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$19,474.00**

Program Income	Received To Date	Expended To Date	Remaining Balance

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Ashley
Date: 8-9-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Castledy
Date: 8-14-2017

Program Accountant
By: Total?
Date:

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ECONOMIC ASSISTANCE

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 6/1/2017 To: 6/30/2017

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, If Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, If Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, If Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$34,463.00	$3,133.00	$37,596.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$147,124.00	$16,561.00	$163,685.00	$146,965.50			
Equipment							
Supplies	$385.00	$35.00	$420.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$4,293.00	$449.00	$4,742.00	$9,984.00			
Advertising	$21,664.00	$2,000.00	$23,664.00	$50,000.00			
Administration/Indirect Costs	$3,443.00	$313.00	$3,756.00	$3,759.50			
Sub-Total	$211,372.00	$22,491.00	$233,863.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$211,372.00		$233,863.00	$250,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$22,491.00**

Program Income | Received To Date | Expended To Date | Remaining Balance

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [ ] No [X] Yes

Payee Signature: Amber Hendy
Date: 7-10-17

Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director By:
Date:

Division Director By: Carol Carlberg
Date: 7-11-2017

Program Accountant By:
Date:

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

ECONOMIC ASSISTANCE

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION	Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Description of Service: Alternatives to Abortion	Salaries & Fringe Benefit (Employees Only)	$31,330.00	$3,133.00	$34,463.00	$37,596.00			
	Travel				$1,275.00			
DHS Contract Number: 405-10375	Consultation Services	$132,352.00	$14,772.00	$147,124.00	$146,965.50			
	Equipment							
	Supplies	$350.00	$35.00	$385.00	$420.00			
	Training							
	Other (List Separately)							
	Contractual Services	$3,961.00	$332.00	$4,293.00	$9,984.00			
	Advertising	$17,664.00	$4,000.00	$21,664.00	$50,000.00			
	Administration/Indirect Costs	$3,130.00	$313.00	$3,443.00	$3,759.50			
Contract Period: From: 7/1/2016 To: 6/30/2017	Sub-Total	$188,787.00	$22,585.00	$211,372.00				
Billing Period: From: 5/1/2017 To: 5/31/2017	*Less* Advances/Program Income	( )	( )	( )				
	Totals	$188,787.00		$211,372.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$22,585.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 6-9-17

Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 6-14-2017

Program Accountant
By:
Date:

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ECONOMIC ASSISTANCE
REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION
I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hadley
Date: 5-10-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL
Program Director By:
Date:
Division Director By: Carol Cartledge
Date: 5-15-2017
Program Accountant By:
Date:

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 4/1/2017 To: 4/30/2017

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$28,197.00	$3,133.00	$31,330.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$122,080.00	$10,272.00	$132,352.00	$146,965.50			
Equipment							
Supplies	$315.00	$35.00	$350.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$3,512.00	$449.00	$3,961.00	$9,984.00			
Advertising	$13,664.00	$4,000.00	$17,664.00	$50,000.00			
Administration/Indirect Costs	$2,817.00	$313.00	$3,130.00	$3,759.50			
Sub-Total	$170,585.00	$18,202.00	$188,787.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$170,585.00		$188,787.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$18,202.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 3/1/2017 To: 3/31/2017

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$25,064.00	$3,133.00	$28,197.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$105,388.00	$16,692.00	$122,080.00	$146,965.50			
Equipment							
Supplies	$280.00	$35.00	$315.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$3,122.00	$390.00	$3,512.00	$9,984.00			
Advertising	$9,664.00	$4,000.00	$13,664.00	$50,000.00			
Administration/Indirect Costs	$2,504.00	$313.00	$2,817.00	$3,759.50			
Sub-Total	$146,022.00	$24,563.00	$170,585.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$146,022.00		$170,585.00	$250,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$24,563.00**

	Received To Date	Expended To Date	Remaining Balance
Program Income			

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 4-12-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director By:
Date:

Division Director By: Carol Cartledge
Date: 4-17-2017

Program Accountant By:
Date:

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hensley
Date: 3-9-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Cartledge
Date: 3-13-2017

Program Accountant
By:
Date:

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 2/1/2017 To: 2/28/2017

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$21,931.00	$3,133.00	$25,064.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$95,528.00	$9,860.00	$105,388.00	$146,965.50			
Equipment							
Supplies	$245.00	$35.00	$280.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$2,732.00	$390.00	$3,122.00	$9,984.00			
Advertising	$5,579.00	$4,085.00	$9,664.00	$50,000.00			
Administration/Indirect Costs	$2,191.00	$313.00	$2,504.00	$3,759.50			
Sub-Total	$128,206.00	$17,816.00	$146,022.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$128,206.00		$146,022.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$17,816.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT, DIRECT SERVICE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 2-2017)

ECONOMIC ASSISTANCE

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hedley
Date: 2-10-17
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director By: Carol Carlson
Date: 2-13-2017
Division Director By:
Date:
Program Accountant By:
Date:

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 1/1/2017 To: 1/31/2017

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$18,798.00	$3,133.00	$21,931.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$85,132.00	$10,396.00	$95,528.00	$146,965.50			
Equipment							
Supplies	$210.00	$35.00	$245.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$2,342.00	$390.00	$2,732.00	$9,984.00			
Advertising		$5,579.00	$5,579.00	$50,000.00			
Administration/Indirect Costs	$1,878.00	$313.00	$2,191.00	$3,759.50			
Sub-Total	$108,360.00	$19,846.00	$128,206.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$108,360.00		$128,206.00	$250,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$19,846.00**

Program Income	Received To Date	Expended To Date	Remaining Balance

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 12/1/2016 To: 12/31/2016

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$15,665.00	$3,133.00	$18,798.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$72,212.00	$12,920.00	$85,132.00	$146,965.50			
Equipment							
Supplies	$175.00	$35.00	$210.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$1,952.00	$390.00	$2,342.00	$9,984.00			
Advertising				$50,000.00			
Administration/Indirect Costs	$1,565.00	$313.00	$1,878.00	$3,759.50			
Sub-Total	$91,569.00	$16,791.00	$108,360.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$91,569.00		$108,360.00	$250,000.00			

	Received To Date	Expended To Date	Remaining Balance
Program Income			

Total Amount Requested for Reimbursement: (This billing period) **$16,791.00**

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hendrickson
Date: 1-16-17

Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 1-19-2017

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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ECONOMIC ASSISTANCE
REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hedley
Date: 12-13-16
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 11/1/2016 To: 11/30/2016

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$12,532.00	$3,133.00	$15,665.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$60,768.00	$11,444.00	$72,212.00	$146,965.50			
Equipment							
Supplies	$140.00	$35.00	$175.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$1,562.00	$390.00	$1,952.00	$9,984.00			
Advertising				$50,000.00			
Administration/Indirect Costs	$1,252.00	$313.00	$1,565.00	$3,759.50			
Sub-Total	$76,254.00	$15,315.00	$91,569.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$76,254.00		$91,569.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$15,315.00**

Program Income

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carstedt
Date: 12-20-16

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 10/1/2016 To: 10/31/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$9,399.00	$3,133.00	$12,532.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$45,412.00	$15,356.00	$60,768.00	$146,965.50			
Equipment							
Supplies	$105.00	$35.00	$140.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$1,172.00	$390.00	$1,562.00	$9,984.00			
Advertising	$0.00			$50,000.00			
Administration/Indirect Costs	$939.00	$313.00	$1,252.00	$3,759.50			
Sub-Total	$57,027.00	$19,227.00	$76,254.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$57,027.00		$76,254.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$19,227.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 11-10-16
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlbdg
Date: 11-17-2016

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

COPY

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hanley
Date: 10-11-16
Payee Telephone Number: 701-451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 9/1/0156 To: 9/30/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$6,266.00	$3,133.00	$9,399.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$30,552.00	$14,860.00	$45,412.00	$146,965.50			
Equipment							
Supplies	$70.00	$35.00	$105.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$782.00	$390.00	$1,172.00	$9,984.00			
Advertising	$0.00	$0.00		$50,000.00			
Administration/Indirect Costs	$626.00	$313.00	$939.00	$3,759.50			
Sub-Total	$38,296.00	$18,731.00	$57,027.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$38,296.00		$57,027.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$18,731.00**

Program Income

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlberg
Date: 10-24-2016

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

ECONOMIC ASSISTANCE

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 8/1/2016 To: 8/31/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$3,133.00	$3,133.00	$6,266.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$15,064.00	$15,488.00	$30,552.00	$146,965.50			
Equipment							
Supplies	$35.00	$35.00	$70.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$391.00	$391.00	$782.00	$9,984.00			
Advertising	$0.00	$0.00		$50,000.00			
Administration/Indirect Costs	$313.00	$313.00	$626.00	$3,759.50			
Sub-Total	$18,936.00	$19,360.00	$38,296.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$18,936.00		$38,296.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$19,360.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hershy
Date: 9-20-16
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 9-23-2016

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

COPY

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-10375

Contract Period: From: 7/1/2016 To: 6/30/2017

Billing Period: From: 7/1/2016 To: 7/31/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, If Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)		$3,133.00	$3,133.00	$37,596.00			
Travel				$1,275.00			
Consultation Services		$15,064.00	$15,064.00	$146,965.50			
Equipment							
Supplies		$35.00	$35.00	$420.00			
Training							
Other (List Separately)							
Contractual Services		$391.00	$391.00	$9,984.00			
Advertising		$0.00		$50,000.00			
Administration/Indirect Costs		$313.00	$313.00	$3,759.50			
Sub-Total		$18,936.00	$18,936.00				
Less Advances/Program Income	( )	( )	( )				
Totals			$18,936.00	$250,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$18,936.00**

Program Income	Received To Date	Expended To Date	Remaining Balance

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Timber Hensley

Date: 8-10-16

Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director By:

Date:

Division Director By: Carol Carlsdg

Date: 8-16-2016

Liaison Accountant By:

Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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AUG 15 2016
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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 6/1/2016 To: 6/30/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$34,463.00	$3,133.00	$37,596.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$158,138.00	$19,512.00	$177,650.00	$146,965.50			
Equipment							
Supplies	$386.00	$35.00	$421.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$4,298.00	$449.00	$4,747.00	$9,984.00			
Advertising	$83.00	$0.00	$83.00	$50,000.00			
Administration/Indirect Costs	$3,443.00	$313.00	$3,756.00	$3,759.50			
Sub-Total	$200,811.00	$23,442.00	$224,253.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$200,811.00		$224,253.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$23,442.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
☐ No ☒ Yes

Payee Signature: Amber Hustey
Date: 7-7-16
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 7-11-2016

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION
I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Pamela Hurley
Date: 6-14-16
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 5/1/2016 To: 5/31/2016

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$31,330.00	$3,133.00	$34,463.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$146,538.00	$11,600.00	$158,138.00	$146,965.50			
Equipment							
Supplies	$351.00	$35.00	$386.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$3,907.00	$391.00	$4,298.00	$9,984.00			
Advertising	$83.00	$0.00	$83.00	$50,000.00			
Administration/Indirect Costs	$3,130.00	$313.00	$3,443.00	$3,759.50			
Sub-Total	$185,339.00	$15,472.00	$200,811.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$185,339.00		$200,811.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$15,472.00**

Program Income

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carledge
Date: 6-17-2016

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE
ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION
I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hensley
Date: 5-16-16
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 4/1/2016 To: 4/30/2016

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$28,197.00	$3,133.00	$31,330.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$126,624.00	$19,914.00	$146,538.00	$146,965.50			
Equipment							
Supplies	$316.00	$35.00	$351.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$3,575.00	$332.00	$3,907.00	$9,984.00			
Advertising	$83.00		$83.00	$50,000.00			
Administration/Indirect Costs	$2,817.00	$313.00	$3,130.00	$3,759.50			
Sub-Total	$161,612.00	$23,727.00	$185,339.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$161,612.00		$185,339.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) $23,727.00

Program Income

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 5-18-2016

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 4-6-16
Payee Telephone Number: 701-451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 3/1/2016 To: 3/31/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$25,064.00	$3,133.00	$28,197.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$108,380.00	$18,244.00	$126,624.00	$146,965.50			
Equipment							
Supplies	$281.00	$35.00	$316.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$3,126.00	$449.00	$3,575.00	$9,984.00			
Advertising	$83.00		$83.00	$50,000.00			
Administration/Indirect Costs	$2,504.00	$313.00	$2,817.00	$3,759.50			
Sub-Total	$139,438.00	$22,174.00	$161,612.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$139,438.00		$161,612.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) $22,174.00

Program Income

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Cartledge
Date: 4-8-2016

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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ECONOMIC ASSISTANCE

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 3-15-16
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Arlene Dunn
Date: 3-18-16

Liaison Accountant
By:
Date:

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 2/1/2016 To: 2/29/2016

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$21,931.00	$3,133.00	$25,064.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$98,724.00	$9,656.00	$108,380.00	$146,965.50			
Equipment							
Supplies	$246.00	$35.00	$281.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$2,677.00	$449.00	$3,126.00	$9,984.00			
Advertising	$83.00		$83.00	$50,000.00			
Administration/Indirect Costs	$2,191.00	$313.00	$2,504.00	$3,759.50			
Sub-Total	$125,852.00	$13,586.00	$139,438.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$125,852.00		$139,438.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$13,586.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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ECONOMIC ASSISTANCE

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 2-15-16
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 1/1/2016 To: 1/31/2016

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$18,798.00	$3,133.00	$21,931.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$85,248.00	$13,476.00	$98,724.00	$146,965.50			
Equipment							
Supplies	$211.00	$35.00	$246.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$2,345.00	$332.00	$2,677.00	$9,984.00			
Advertising	$83.00		$83.00	$50,000.00			
Administration/Indirect Costs	$1,878.00	$313.00	$2,191.00	$3,759.50			
Sub-Total	$108,563.00	$17,289.00	$125,852.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$108,563.00		$125,852.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$17,289.00**

Program Income

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlson
Date: 2-18-2016

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: THe Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 12/1/2015 To: 12/31/2015

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$15,665.00	$3,133.00	$18,798.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$73,436.00	$11,812.00	$85,248.00	$146,965.50			
Equipment							
Supplies	$176.00	$35.00	$211.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$1,954.00	$391.00	$2,345.00	$9,984.00			
Advertising	$83.00	$0.00	$83.00	$50,000.00			
Administration/Indirect Costs	$1,565.00	$313.00	$1,878.00	$3,759.50			
Sub-Total	$92,879.00	$15,684.00	$108,563.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$92,879.00		$108,563.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$15,684.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hanley
Date: 1-19-16
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Carlberg
Date: 1-21-2016

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

ECONOMIC ASSISTANCE

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 11/1/2015 To: 11/30/2015

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$12,532.00	$3,133.00	$15,665.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$59,808.00	$13,628.00	$73,436.00	$146,965.50			
Equipment							
Supplies	$141.00	$35.00	$176.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$1,563.00	$391.00	$1,954.00	$9,984.00			
Advertising	$83.00	$0.00	$83.00	$50,000.00			
Administration/Indirect Costs	$1,252.00	$313.00	$1,565.00	$3,759.50			
Sub-Total	$75,379.00	$17,500.00	$92,879.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$75,379.00		$92,879.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$17,500.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hustad
Date: 12-15-15
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Tom Sibley
Date: 12/21/2015

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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ECONOMIC ASSISTANCE

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 10/1/2015 To: 10/31/2015

Expenditure Classification	Column A Total Expenditures Previously Claimed	Column B Expenditures Claimed This Billing Period	Column C Cumulative Expenditures To Date Columns A & B	Column D Total Contract Award (Including all Amendments)	Column E Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$9,399.00	$3,133.00	$12,532.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$45,876.00	$13,932.00	$59,808.00	$146,965.50			
Equipment							
Supplies	$105.00	$36.00	$141.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$1,173.00	$390.00	$1,563.00	$9,984.00			
Advertising	$83.00	$0.00	$83.00	$50,000.00			
Administration/Indirect Costs	$939.00	$313.00	$1,252.00	$3,759.50			
Sub-Total	$57,575.00	$17,804.00	$75,379.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$57,575.00		$75,379.00	$250,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$17,804.00**

Program Income	Received To Date	Expended To Date	Remaining Balance

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Wesley
Date: 11-12-15
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Cartledge
Date:

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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ECONOMIC ASSISTANCE

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 9/1/2015 To: 9/30/2015

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$6,266.00	$3,133.00	$9,399.00	$37,596.00			
Travel				$1,275.00			
Consultation Services	$32,872.00	$13,004.00	$45,876.00	$146,965.50			
Equipment							
Supplies	$70.00	$35.00	$105.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$782.00	$391.00	$1,173.00	$9,984.00			
Advertising	$0.00	$83.00	$83.00	$50,000.00			
Administration/Indirect Costs	$626.00	$313.00	$939.00	$3,759.50			
Sub-Total	$40,616.00	$16,959.00	$57,575.00				
Less Advances/Program Income	( )	( )	( )				
Totals	$40,616.00		$57,575.00	$250,000.00			

Received To Date	Expended To Date	Remaining Balance

Program Income

Total Amount Requested for Reimbursement: (This billing period) **$16,959.00**

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Amber Hurley
Date: 10-13-15
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Castle
Date: 10-19-2015

Liaison Accountant
By:
Date:

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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ECONOMIC ASSISTANCE REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box)
[X] No [ ] Yes

Payee Signature: Tina Heisler
Date: 9-14-15
Payee Telephone Number: (701) 451-4864

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Castle
Date: 09-17-2015

Liaison Accountant
By:
Date:

CONTRACT INFORMATION	Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Description of Service: Alternatives to Abortion	Salaries & Fringe Benefit (Employees Only)	$3,133.00	$3,133.00	$6,266.00	$37,596.00			
	Travel				$1,275.00			
DHS Contract Number: 405-08616	Consultation Services	$16,980.00	$15,892.00	$32,872.00	$146,965.50			
	Equipment							
	Supplies	$35.00	$35.00	$70.00	$420.00			
	Training							
	Other (List Separately)							
	Contractual Services	$391.00	$391.00	$782.00	$9,984.00			
	Advertising	$0.00			$50,000.00			
	Administration/Indirect Costs	$313.00	$313.00	$626.00	$3,759.50			
Contract Period: From: 7/1/2015 To: 6/30/2016	Sub-Total	$20,852.00	$19,764.00	$40,616.00				
Billing Period: From: 8/1/2015 To: 8/31/2015	*Less* Advances/Program Income	( )	( )	( )				
	Totals	$20,852.00		$40,616.00	$250,000.00	Received To Date	Expended To Date	Remaining Balance

Total Amount Requested for Reimbursement: (This billing period) **$19,764.00**

Program Income

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

REQUEST FOR REIMBURSEMENT- DIRECT SERVICE

ND DEPARTMENTOF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1763 (Rev. 09-2005)

(See reverse for instructions on completing this form).

Vendor/ Provider Name: The Village Family Service Center
Address Line 1: PO Box 9859
Line 2:
City: Fargo | State: ND | Zip Code: 58106

PAYEE CERTIFICATION

I hereby certify that this request accurately reflects expenditures for services rendered in accordance with an agreement between the *vendor/provider* organization or agency identified above and the North Dakota Department of Human Services, that matching fund requirements have been complied with and that such compliance is documented for audit purposes.

Is this the final reimbursement request for this contract? (Please check a box) [X] No [ ] Yes

Payee Signature: Amber Hedley
Date: 8-17-15
Payee Telephone Number: (701) 451-4864

CONTRACT INFORMATION

Description of Service: Alternatives to Abortion

DHS Contract Number: 405-08616

Contract Period: From: 7/1/2015 To: 6/30/2016

Billing Period: From: 7/1/2015 To: 7/31/2015

Expenditure Classification	Column A: Total Expenditures Previously Claimed	Column B: Expenditures Claimed This Billing Period	Column C: Cumulative Expenditures To Date Columns A & B	Column D: Total Contract Award (Including all Amendments)	Column E: Total Matching Expenditures (Including In-Kind, if Allowable) Previously Reported	Column F: Matching Expenditures (Including In-Kind, if Allowable) This Billing Period	Column G: Cumulative Matching Expenditures (Including In-Kind, if Allowable) to Date Columns E & F
Salaries & Fringe Benefit (Employees Only)	$0.00	$3,133.00	$3,133.00	$37,596.00			
Travel	$0.00	$0.00		$1,275.00			
Consultation Services	$0.00	$16,980.00	$16,980.00	$146,965.50			
Equipment							
Supplies	$0.00	$35.00	$35.00	$420.00			
Training							
Other (List Separately)							
Contractual Services	$0.00	$391.00	$391.00	$9,984.00			
Advertising	$0.00	$0.00		$50,000.00			
Administration/Indirect Costs	$0.00	$313.00	$313.00	$3,759.50			
Sub-Total		$20,852.00	$20,852.00				
Less Advances/Program Income	( )	( )	( )				
Totals			$20,852.00	$250,000.00			

Total Amount Requested for Reimbursement: (This billing period) **$20,852.00**

Program Income	Received To Date	Expended To Date	Remaining Balance

DEPARTMENT APPROVAL

Program Director
By:
Date:

Division Director
By: Carol Castledy
Date: 8-19-2015

Liaison Accountant
By:
Date:

DHS FINANCE USE ONLY:

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT

DISTRIBUTION:
White/Canary - Finance
Canary - returned to vendor/provider with check
Pink - retained by vendor/provider

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AUG 19 2015
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